

MDR Tracking Number: M5-04-1718-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 2-12-04.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits, electrical stimulation, ultrasound, mechanical traction, and supplies from 2/12/03 through 5/16/03 **were found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed service.

This Findings and Decision is hereby issued this 10th day of May 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby **ORDERS** the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 2/12/03 through 5/16/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Decision and Order is hereby issued this 5th day of May 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RC/rlc

April 29, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-1718-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 42 year-old female who sustained a work related injury on ___. The patient reported that while at work she fell injuring her head, neck, and back. The results of x-rays of the lumbar, thoracic and cervical spine were reported to be normal. A MRI of the lumbar spine on 1/2/03 was also reported to be normal. The patient was initially treated with chiropractic care consisting of physical modalities, active home rehab with cryotherapy, exercise routine, water aerobics, range of motion flexibility exercising, lumbosacral support and a TENS unit. The patient was referred to a chronic pain specialist and underwent a sacroiliac joint injection on 3/26/03. The patient continued with physical therapy and oral medications. The diagnoses for this patient have included sacroilitis and lumbar muscle strain.

Requested Services

Electrical stimulation unattended, ultrasound, office visit, supplies/materials, and mechanical traction from 2/12/03 through 5/16/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is overturned.

Rationale/Basis for Decision

The ____ chiropractor reviewer noted that this case concerns a 42 year-old female who sustained a work related injury to her head, neck and back on _____. The ____ chiropractor reviewer also noted that the diagnoses for this patient have included sacroilitis and lumbar muscle strain. The ____ chiropractor reviewer further noted that the treatment for this patient's condition has included chiropractic care, physical modalities, active home rehab with cryotherapy, exercise routine, water aerobics, range of motion flexibility exercising, lumbosacral support, TENS unit, oral medications, and sacroiliac injections. The ____ chiropractor reviewer indicated that this patient suffered multiple areas of involvement with the initial injury. The ____ chiropractor reviewer noted that the most pain this patient is experiencing is in the low back and leg. The ____ chiropractor reviewer explained that although an MRI was negative, the patient showed signs of an internal disc derangement that may require discogram to identify. The ____ chiropractor reviewer noted that the patient received significant benefit from the chiropractic care she received. The ____ chiropractor reviewer also noted that the patient was found to be not a maximal medical improvement on 4/22/03 and that the recommendation was for continued conservative care. The ____ chiropractor reviewer explained that the care given was medically necessary. The ____ chiropractor reviewer also explained that this patient's treating chiropractor reviewer managed this patient's care appropriately and has made appropriate referrals for additional help. Therefore, the ____ chiropractor consultant concluded that the electrical stimulation unattended, ultrasound, office visit, supplies/materials, and mechanical traction from 2/12/03 through 5/16/03 were medically necessary to treat this patient's condition.

Sincerely,